

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of:

Case No: 13A-9796-MDX

3 **ROBERT C. OSBORNE, M.D.,**

Board Case No. MD-12-0771A

4 Holder of License No. 9796  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER  
(Revocation)**

7 On June 11, 2014, this matter came before the Arizona Medical Board ("Board")  
8 for consideration of the Administrative Law Judge (ALJ) Tammy L. Eigenheer's proposed  
9 Findings of Fact, Conclusions of Law and Recommended Order. Robert C. Osborne,  
10 M.D., ("Respondent") appeared before the Board with legal counsel James Stuehringer;  
11 Assistant Attorney General Anne Froedge, represented the State. Diana Day with the  
12 Solicitor General's Section of the Attorney General's Office, was available to provide  
13 independent legal advice to the Board.

14 The Board, having considered the ALJ's decision and the entire record in this  
15 matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

16 **FINDINGS OF FACT**

- 17 1. The Arizona Medical Board (Board) is the authority for the regulation and control of  
the practice of allopathic medicine in the State of Arizona.
- 18 2. Robert C. Osborne, M.D. (Respondent) is the holder of license number 9796 for  
19 the practice of allopathic medicine in the State of Arizona. Respondent has practiced  
20 medicine for 44 years. While Respondent is not board-certified in pain management, he  
has practiced pain management since 1995.
- 21 3. On September 24, 2013, the Board Issued a Complaint and Notice of Hearing to  
22 Respondent alleging that Respondent had engaged in unprofessional conduct pursuant  
23 to A.R.S. § 32-1401(27)(e) ("failing or refusing to maintain adequate records on a  
24 patient") and A.R.S. § 32-1401(27)(q) ("any conduct or practice that is or might be  
25 harmful or dangerous to the health of the patient or the public").

Background

4. On June 22, 2012, the Board received a complaint from a physician at COPE Community Services, Inc. (COPE), a behavioral health services provider, that alleged inappropriate prescribing of opioids during Respondent's care and treatment of patients SM and SJ.<sup>1</sup>

5. The Board assigned Danielle Steger to investigate the complaint. On June 22, 2012, Ms. Steger notified Respondent of the investigation and requested his medical records for SM and SJ.<sup>2</sup> Ms. Steger also obtained the Arizona State Board of Pharmacy's Controlled Substances Prescription Monitoring Program (CSPMP) reports for SM and SJ.<sup>3</sup>

6. After completing the case file, the matter was forwarded to Jeremy Julian Grove, M.D., an outside medical consultant, for review. Dr. Grove is board-certified in anesthesiology and pain management, completed a year-long fellowship in pain management at Harvard Brigham and Women's Hospital in Boston, Massachusetts, and is the current president of the Arizona Pain Society.<sup>4</sup>

7. Dr. Grove prepared a written report detailing deviations from the standard of care that he observed in Respondent's treatment of SM and SJ.<sup>5</sup>

8. The Board's Staff Investigational Review Committee (SIRC) reviewed Dr. Grove's report and requested a second medical consultant review.

9. The case file was then forwarded to Richard Ruskin, M.D., for review. Dr. Ruskin is board-certified in both anesthesiology and pain management, completed a pain fellowship at the Medical College of Wisconsin, and is a partner at Desert Pain Institute, a multidisciplinary pain practice.<sup>6</sup>

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<sup>1</sup> State's Exhibit 1.

<sup>2</sup> State's Exhibit 2.

<sup>3</sup> State's Exhibits 3 and 4.

<sup>4</sup> Court Reporter's Transcript (Tr.) 227:11-228:1.

<sup>5</sup> State's Exhibit 10.

<sup>6</sup> Tr. 87:17-90:2

1 10. Dr. Ruskin prepared a written report detailing deviations from the standard of care  
2 that he observed in Respondent's treatment of SM and SJ. Dr. Ruskin also opined that  
3 Respondent's medical records were inadequate.<sup>7</sup>

4 Patient SM

5 11. Patient SM is a 44-year-old woman who was seen by Respondent approximately  
6 monthly from May 12, 2010,<sup>8</sup> through June 25, 2012, for treatment of chronic pain.<sup>9</sup>

7 12. In the Complaint and Notice of Hearing, the Board alleged six deviations from the  
8 standard of care in Respondent's treatment and care of SM as outlined below.

9 *Respondent's failure to provide a coherent and organized history, physical examination,*  
10 *assessment, and plan of care for SM*

11 13. At SM's first appointment with Respondent, she indicated she was experiencing  
12 neck and upper extremity pain and pain in the shoulder, hand, and wrist. SM also  
13 reported a history of migraine and tension headaches.<sup>10</sup>

14 14. Respondent's initial progress note for SM provided a general overview of SM's  
15 medical history.<sup>11</sup>

16 15. At the initial appointment, SM submitted to a urine drug screen that was positive  
17 for oxycodone and benzodiazepines.<sup>12</sup>

18 16. With respect to physical findings, Respondent's initial progress note provided as  
19 follows:

20  
21 HEENT is negative. Tympanic membrane, mouth and nose are negative.  
22 Neck is negative. Chest is clear. Heart is regular. Abdomen is nontender.  
23 Shoulders, elbows and wrists are negative. Hips, knees and ankles are  
24 negative. Cranial nerves- 3, 4, 6, 5, 7, 11, 12 are negative. Sensory exam  
25 and the upper extremities are negative. Motor exam is negative. Reflexes  
are normal. Babinsky and Romberg are negative.

21 <sup>7</sup> State's Exhibit 15.

22 <sup>8</sup> Respondent's progress notes indicate SM's first appointment was on May 14, 2010. See Respondent's  
23 Vol. 1, SM's records, 54. However, other parts of Respondent's records indicate SM's first appointment  
24 was on May 12, 2010. See *id.* at 9, 10, 13, 19, and 97. For purposes of this Decision, May 12, 2010, will  
25 be used for consistency and clarity.

<sup>9</sup> The testimony provided at the hearing indicated that Respondent continued to treat SM through the time  
of the hearing, but the medical records submitted into evidence only document Respondent's treatment of  
SM through June 25, 2012.

<sup>10</sup> Respondent's Vol. 1, SM's records, 54-55.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* at 55.

1 Range of motion of her neck is 20 degrees flexion, five degrees of  
2 extension and 20 degrees lateral flexion.<sup>13</sup>

3 17. With respect to a plan of care, Respondent's progress note provided, "I am quite  
4 supportive of a person that has seen a surgeon. I encourage her to stop her smoking  
and [get] her surgery."<sup>14</sup>

5 18. At the second appointment on June 8, 2010, Respondent's progress note  
6 provided, "I have slightly increased her medications and will try to be supportive of her. I  
7 do think she needs intermittent [sic] surgery."<sup>15</sup>

8 19. Respondent's August 3, 2010 progress note indicated that he reviewed SM's  
records from Tucson Orthopaedic Institute and determined "she does need surgery."<sup>16</sup>

9 20. Respondent's August 31, 2010 progress note indicated that Respondent  
10 recommended that SM reconsider surgery as he believed it would have a positive  
11 outcome.<sup>17</sup>

12 21. Many of Respondent's progress notes during the course of his treatment of SM  
13 ended with a statement to the effect of "I am supportive of this woman and will follow her  
monthly."<sup>18</sup>

14 *Respondent's failure to more thoroughly consider what other treatment modalities might*  
15 *be available rather than continuing to escalate her opioid dosage*

16 22. SM underwent a cervical selective nerve root block in August 2009, but reported at  
17 that time that it was not helpful.<sup>19</sup> During the hearing, SM testified that she did have  
some relief as a result of the injection.

18 23. On October 8, 2009, SM underwent an initial evaluation for physical therapy. The  
19 initial evaluation indicated that SM would attend physical therapy twice a week for four to  
20 eight weeks and that her rehabilitation potential was good.<sup>20</sup>

21  
22 <sup>13</sup> *Id.*

23 <sup>14</sup> *Id.*

<sup>15</sup> *Id.* at 53.

24 <sup>16</sup> *Id.* at 51.

<sup>17</sup> *Id.* at 50.

25 <sup>18</sup> *See id.* at 22-36, 40, 41, 44, 45, 50, and 52.

<sup>19</sup> *Id.* at 147

<sup>20</sup> *Id.* at 164-5

1 24. On October 28, 2009, SM was discharged from physical therapy for  
2 noncompliance. It was noted that SM attended two appointments and missed four  
3 appointments since she initiated treatment.<sup>21</sup> During the hearing, SM testified that  
4 physical therapy made the pain worse.

5 25. SM's previous treating physician had recommended that she undergo surgery for  
6 a herniated disc at C5-6 and C6-7 after she quit smoking.<sup>22</sup>

7 26. Respondent acknowledged that he did not recommend physical therapy, epidural  
8 steroid injections, or any other treatment modalities for SM at any point during her  
9 treatment. Respondent's only plan of care was to prescribe pain medication until SM quit  
10 smoking, lost weight, and was able to undergo surgery.

11 27. While Respondent mentioned encouraging SM to lose weight in his records,  
12 Respondent did not directly address the issue with a weight-loss or exercise plan or  
13 medications. According to Respondent's records, SM weighed 214 pounds at her first  
14 appointment on May 12, 2010, and weighed 232 pounds at her appointment on April 30,  
15 2012.<sup>23</sup> However, SM testified at the hearing that she weighed 200 pounds and had lost  
16 80 pounds since she started seeing Respondent.

17 28. At the time of the hearing, close to four years after SM began treatment with  
18 Respondent, she had not had the recommended surgery.

19 29. According to Respondent's testimony, he does not believe that physical therapy is  
20 an effective treatment modality as it may decrease pain while the patient is undergoing  
21 the therapy, but it does not result in any long-term pain reduction. Respondent testified  
22 that he refers approximately two to three percent of his patients to physical therapy.<sup>24</sup>

23 30. Similarly, Respondent does not believe that epidural steroid injections would be  
24 effective in the treatment of SM's condition based on her pathology. Respondent  
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<sup>21</sup> *Id.* at 166

<sup>22</sup> *Id.* at 150.

<sup>23</sup> *Id.* at 18-19.

<sup>24</sup> Tr. 742:22-24.

1 submitted an article in support of his position.<sup>25</sup> Further, Respondent testified that he  
2 refers approximately two to three percent of his patients for epidural steroid injections.<sup>26</sup>

3 31. Dr. Grove testified that a treatment modality may work even if that treatment  
4 modality had failed in the past and that "physical therapy is a lot about timing."<sup>27</sup>

5 *Respondent's failure to document a clear rationale as to why Respondent felt it was*  
6 *necessary to accelerate SM's opioid dosage to the level of 600 morphine mg-equivalents*  
7 *per day*

8 32. Prior to seeing Respondent, SM was taking opioids including oxycodone 30mg (5  
9 tablets per day) and Fioricet. Dr. Grove testified this was approximately 200 to 300  
10 morphine mg-equivalent.

11 33. At SM's second appointment with Respondent on June 8, 2010, Respondent  
12 noted that she "returns to this clinic stabilized on her medications." Despite this finding,  
13 Respondent doubled SM's prescription to 300 tablets of oxycodone 30mg per 30 days.  
14 Respondent also gave SM a long-acting opioid by prescribing 90 tablets of oxycontin  
15 80mg per 30 days. Respondent recorded in the progress note that "I have *slightly*  
16 increased her medications and will try to be supportive of her."<sup>28</sup>

17 34. On December 15, 2011, Respondent increased the prescription from 300 tablets  
18 to 360 tablets of oxycodone 30mg per 30 days.

19 35. Respondent's December 15, 2011 progress note provided as follows:

20 [SM] returns to this clinic stabilized on her medicine. There are not  
21 undercurrent changes.

22 She indicates she is trying to decrease her smoking. She is being followed  
23 by COPE and she takes neurontin and COPE has decided this is not a  
24 psychiatric drug meaning they do not want to pay for it.

25 I have refilled her prescription with 3 refills 300 mg 3 times a day.

26 I will be quite supportive of this woman and follow her on a regular basis.<sup>29</sup>

27 Nothing in Respondent's record indicates why the medication was increased at that time.

28 <sup>25</sup> Respondent's Exhibit Vol. 5, Tab 3.

29 <sup>26</sup> Tr. 742:25-743:2.

30 <sup>27</sup> Tr. 334:15-21.

31 <sup>28</sup> Respondent's Vol. 1, SM's records, 53 (emphasis added).

32 <sup>29</sup> /d. at 28

*Respondent's failure to take into account SM's co-morbid conditions, including her 10-year history of methamphetamine addiction, as well as bipolar disorder*

36. At the initial appointment, SM reported a history of methamphetamine addiction from 1998 through 2008. SM also indicated a history of psychiatric treatment for bipolar disorder.<sup>30</sup>

37. At the first appointment on May 12, 2010, SM submitted to a urinary drug screen that was positive for oxycodone and benzodiazepines.<sup>31</sup>

38. While Respondent had communication documents from COPE regarding SM's treatment from varying times, it appears the records were first received on November 2, 2010, approximately six months after Respondent began treating SM.<sup>32</sup>

39. It was not until February 15, 2011, that Respondent documented a conversation with SM about her treatment at COPE other than passing mentions of medications she was taking that COPE had prescribed. On February 15, 2011, Respondent noted that SM's COPE sessions were video discussions with someone in another city and that he had "read the names of people originating the review document sent to me and one is a nurse practitioner or nurse's assistant and the other one was a psychiatrist. I certainly question the adequacy of this type of review."<sup>33</sup>

40. In his May 6, 2011 progress note, Respondent did not directly mention COPE, but noted that he had "tried to modify some of her medications to make certain there is no overlap."<sup>34</sup>

41. Respondent's October 21, 2011 progress note indicated that SM was unhappy with COPE's procedures and failure to return calls for assistance.<sup>35</sup>

42. On February 6, 2012, SM signed a document prohibiting Respondent from sending any of her records to any medical provider, including her primary care physician, insurance company, or any other entity.<sup>36</sup>

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<sup>30</sup> *Id.* at 54.

<sup>31</sup> *Id.* at 55 and 97.

<sup>32</sup> *Id.* at 141

<sup>33</sup> *Id.* at 41

<sup>34</sup> *Id.* at 37

<sup>35</sup> *Id.* at 29

<sup>36</sup> *Id.* at 5.

1 43. Respondent's April 2, 2012 progress note indicated that SM "express[ed] to  
2 [Respondent] frustration with her COPE relationship."<sup>37</sup>

3 44. Respondent did not indicate in any of his progress notes that he considered SM's  
4 psychiatric issues in dealing with her pain management issues.

5 45. During his testimony, Respondent appeared to dismiss SM's psychiatric issues as  
6 a completely separate issue being dealt with by COPE while he was responsible for her  
7 pain management issues.

8 46. Dr. Ruskin testified that significant psychiatric disease is a "known risk factor for  
9 opioid addiction and abuse."<sup>38</sup>

10 47. Dr. Grove testified that he had a "tremendous concern" regarding SM's refusal to  
11 allow Respondent to disclose her medical records to any other provider.<sup>39</sup> Dr. Grove  
12 indicated that he would find it necessary to have an avenue of communication open to  
13 SM's psychiatrist.<sup>40</sup>

14 *Respondent's failure to recognize and intervene when there were clear signs of opioid*  
15 *misuse and diversion*

16 48. The CSPMP indicated that between December 14, 2009, and March 22, 2010, SM  
17 was prescribed opioids by 11 different providers and filled those prescriptions at four  
18 different pharmacies.<sup>41</sup>

19 49. On May 12, 2010, and January 9, 2012, SM signed a narcotics agreement with  
20 Respondent in which SM agreed that she would only obtain prescriptions for narcotics  
21 from Respondent and would use only one pharmacy to obtain her narcotics.<sup>42</sup>

22 50. After June 8, 2010, SM consistently obtained refills for both the oxycodone 30mg  
23 and oxycontin 80mg at least 2 days prior to when the 30 day prescription was scheduled  
24 to run out.<sup>43</sup>

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25 <sup>37</sup> *Id.* at 24

<sup>38</sup> Tr. 119:20-21.

<sup>39</sup> Tr. 242:25-243:2

<sup>40</sup> Tr. 243:3-18.

<sup>41</sup> Joint Exhibit 1.

<sup>42</sup> Respondent's Vol. 1, SM's records, 6 and 114.

<sup>43</sup> Joint Exhibit 1.

1 51. On June 2, 2011, Respondent recorded in his progress note that "[a]pparently  
2 [SM] ran out of her medicine and took one methadone. This was while she was in  
3 Vegas." Respondent went on to say "I am supportive of this woman but I told her this  
4 was unacceptable." Respondent required SM to take a urine drug screen on that date,  
5 which was consistent with her report of the events.<sup>44</sup>

6 52. On June 23, 2011, SM was hospitalized for syncope. The discharge summary  
7 addressed SM's medications as follows:

8 Chronic pain. The patient was continued on her usual very high doses of  
9 oxycodone and OxyContin for her chronic pain. She has been quite  
10 lethargic for most of this hospitalization, but according to her family, this is  
11 her baseline with her medications. I strongly feel that her pain medications  
12 are likely a major contributing factor to most of her symptoms, although we  
13 have found other explanations. She should follow up with [Respondent],  
14 her pain management specialist, as an outpatient and ideally her pain  
15 regimen should be cut as much as possible since she is taking 80 mg of  
16 OxyContin up to 4 times a day and 60 mg of oxycodone up to 7 times a day  
17 at home.<sup>45</sup>

18 53. Respondent admitted that he did not change any aspects of SM's treatment  
19 following the hospitalization because he did not consider the findings to be relevant.

20 54. On August 9, 2011, Respondent recorded in his progress note that SM "returns to  
21 this clinic, there had been a theft by her children. I have Case # . . . . I have given her a  
22 17 day supply. I'll be supportive and follow her on a regular basis."<sup>46</sup> Respondent  
23 acknowledged he did not receive or request a copy of the police report. Respondent  
24 provided SM with prescriptions for hydrocodone, methadone, and Soma for the 17 days  
25 until her next refill of oxycodone and oxycontin. Nothing in the progress notes reflected  
that Respondent substituted different medications and/or provided the rationale for the  
substitution.<sup>47</sup>

55. SM's testimony on this issue was inconsistent. SM first testified that she was  
hospitalized for seven days in August 2011, and that her medications were stolen during

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<sup>44</sup> Respondent's Vol. 1, SM's records, 36 and 92.

<sup>45</sup> *Id.* at 70.

<sup>46</sup> The Case Number was identified in the progress note but is omitted from this decision for confidentiality purposes.

<sup>47</sup> Respondent's Vol. 1, SM's records, 33.

1 her hospitalization. When the Board's counsel pointed out that SM had been hospitalized  
2 for seven days in June 2011, SM then reported she was hospitalized again in August  
3 2011. During an interview with Respondent's counsel on October 18, 2013, SM stated  
4 she and her husband had gone to a casino in Tucson and discovered the medications  
were missing when they returned.<sup>48</sup>

5 56. The CSPMP reports showed that during the course of her treatment with  
6 Respondent, SM filled her medications at multiple pharmacies in violation of the narcotics  
7 agreement. The CSPMP reports also showed that during the course of her treatment  
8 with Respondent, SM obtained narcotics from two other prescribers in violation of the  
9 narcotics agreement. Nothing in Respondent's progress notes indicated that he was  
aware of or had addressed the violations of the narcotics agreement with SM.<sup>49</sup>

10 57. Respondent testified that patients often have to use different pharmacies in the  
11 Tucson area due to a shortage of the medications. SM testified that some pharmacies  
12 would not fill prescriptions from Respondent.<sup>50</sup>

*Respondent's records were inadequate in that they were illegible and incomplete.*

13 58. Respondent's handwritten notes are extremely difficult for a layperson to read.  
14 Additionally, Dr. Ruskin found that the "illegible handwriting and the incompleteness of  
15 the medication record" made Respondent's progression of SM's medication during her  
16 care and treatment "very difficult to follow."<sup>51</sup>

17 59. The progress notes throughout Respondent's treatment of SM are very brief and  
18 do not outline any rationale for the escalating dosage of opioids or overall treatment plan  
other than an eventual surgery.

19 60. Respondent testified that these matters were very straightforward and simple to  
20 him, but he admitted that it would be very confusing to a provider who does not practice  
21 pain management.

22  
23  
24 <sup>48</sup> Respondent's Volume 4, tab K, 14.

<sup>49</sup> Joint Exhibit 1.

25 <sup>50</sup> Tr. 576:3-578:3.

<sup>51</sup> State's Exhibit 15

1 61. Notably, the only progress note in evidence that was created after Respondent  
2 was notified of the complaint was more detailed and included physical examination  
3 findings.<sup>52</sup>

4 Patient SJ

5 62. Patient SJ is a 36-year-old woman who was seen by Respondent from January  
6 16, 2008, through June 1, 2012, for treatment of chronic pain.

7 63. In the Complaint and Notice of Hearing, the Board alleged five deviations from the  
8 standard of care in Respondent's treatment and care of SJ as outlined below.

9 *Respondent's failure to provide a coherent and organized history, physical examination,*  
10 *assessment, and plan of care*

11 64. At SJ's first appointment with Respondent, she indicated that she was  
12 experiencing generalized pain and had a history of lumbar spine surgery. SJ had been  
13 taking Percocet and Vicodin for pain.

14 65. SJ also reported a history of sexual abuse and physical abuse as a child.

15 66. Respondent's initial progress note for SJ provided a general overview of SJ's  
16 medical history.

17 67. With respect to physical findings, the initial progress note provided as follows:

18 Examination of the head, eyes, ear, nose and throat is negative. PERRLA.  
19 Neck is negative.

20 Palpation of the spine she has pain in her mid cervical, mid thoracic and  
21 lumbar sacral and sacro-iliac joints.

22 Her chest is negative. Heart is regular without murmur. Abdomen is soft  
23 and nontender.

24 She has pain in her left wrist and forearm with palpation but it is not  
25 swollen.

Hips, knees and ankles are referred to her sacro-iliac joints.

Cranial nerves 3, 4, 6, 5, 7, 11, and 12 are negative.

Sensory upper extremity is negative. Lower extremity in the right L4  
distribution is decreased sensation.

Motor upper extremity is negative, lower extremity pain.

Reflexes slightly increased in the upper extremity and markedly increased  
in the lower extremity.

She is oriented time 3 and Babinski and Rhomberg are negative.<sup>53</sup>

<sup>52</sup> Respondent's Vol. 1, SM's records, 21-22.

<sup>53</sup> Respondent's Vol. 1, SJ's records, 78-79.

1 68. With respect to a plan of care, the progress note indicated that Respondent  
2 continued SJ on her existing medications and "ordered an HLA-B27" to assist in  
3 determining a diagnosis.<sup>54</sup>

4 69. Respondent's assessment of SJ included ankylosing spondylitis, posterior lumbar  
5 fusion, thoracic degenerative disc disease, cervical disc disease, TMJ, and chronic leg  
6 fatigue.

7 *Respondent's failure to provide clear justification as to why it was necessary to maintain*  
8 *SJ on the equivalent of almost 900 mg of morphine a day*

9 70. Less than two weeks after SJ's first appointment, she returned to the clinic  
10 "stabilized poorly on her medications."<sup>55</sup> Respondent prescribed 240 tablets of  
11 oxycodone 15mg per 30 days and Valium.<sup>56</sup>

12 71. By June 18, 2008, Respondent was prescribing SJ 300 tablets of oxycodone 30mg  
13 per 30 days and Valium.<sup>57</sup>

14 72. Respondent's February 9, 2010 progress note indicated that SJ had taken a job as  
15 a checker at Target that required her to stand for 8 hours. Respondent stated he was  
16 against this position and increased her medications to accommodate her new position.<sup>58</sup>

17 73. Respondent's April 9, 2010, progress note indicated that Respondent "slightly  
18 increased [SJ's] oxycodone and there will be no further increases."<sup>59</sup>

19 74. By May 2010, Respondent was prescribing SJ 420 tablets of oxycodone 30mg per  
20 30 days and 300 tablets of Methadone.<sup>60</sup>

21 75. By May 2011, Respondent was prescribing SJ 480 tablets of oxycodone 30mg per  
22 30 days, 300 tablets of Methadone 10mg, 90 tablets of Alprazolam 1mg per 30 days, and  
23 Ambien.<sup>61</sup>

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24 <sup>54</sup> *Id.* at 79.

25 <sup>55</sup> *Id.* at 76.

<sup>56</sup> Joint Exhibit 2.

<sup>57</sup> *Id.*

<sup>58</sup> Respondent's Vol. 1, SJ's records, 49.

<sup>59</sup> *Id.* at 45.

<sup>60</sup> Joint Exhibit 2.

<sup>61</sup> *Id.*

1 76. The CSPMP indicates that on June 26, 2011, SJ refilled her prescription for 300  
2 tablets of Methadone 10mg.<sup>62</sup>

3 77. On June 29, 2011, SJ reported that her dog had gotten into her purse and  
4 destroyed her medications. The progress note from that day indicated that Respondent  
5 had been "very critical of this. This is her only chance." Respondent did not order a urine  
6 drug screen at that time.<sup>63</sup>

7 78. The CSPMP indicated that on June 29, 2011, SJ filled a prescription for 420  
8 tablets of Hydromorphone 4mg.<sup>64</sup> Nothing in Respondent's progress note indicated that  
9 a different medication was prescribed and/or provided the rationale behind the different  
10 medication.<sup>65</sup>

11 79. On June 22, 2012, the date Respondent was notified of the complaint in the  
12 instant matter, SJ reported an increase in the pain in her lumbosacral spine as well as the  
13 small joints of her hands. SJ also reported that she was not working and did not intend to  
14 return to work.<sup>66</sup> Respondent reduced SJ's prescriptions from 480 tablets to 240 tablets  
15 of oxycodone 30mg per 30 days and from 300 tablets to 180 tablets of Methadone 10mg  
16 per 30 days.<sup>67</sup>

17 80. Respondent cited SJ's lack of work to explain the reduction of medication but did  
18 not explain why such a drastic decrease was appropriate.<sup>68</sup>

19 *Respondent's failure to clarify SJ's co-morbid conditions and work more closely with her*  
20 *rheumatologist and primary care physicians*

21 81. Respondent's January 29, 2008 progress note indicated that Respondent was  
22 "befuddled by the multiple systemic problems [SJ] is having. Lupus/rheumatoid arthritis,  
23 some autoimmune disease seems to be the working diagnosis."<sup>69</sup>

24 82. Respondent's April 1, 2008 progress note indicated that SJ was hospitalized with  
25 swelling in her hands and that it was recommended that she have a rheumatology

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<sup>62</sup> *Id.*

<sup>63</sup> Respondent's Vol. 1, SJ's records, 34.

<sup>64</sup> Joint Exhibit 2.

<sup>65</sup> Respondent's Vol. 1, SJ's records, 34.

<sup>66</sup> *Id.* at 24-25

<sup>67</sup> Joint Exhibit 2.

<sup>68</sup> Respondent's Vol. 1, SJ's records, 24-25.

1 consult with working diagnoses of MS, lupus, or some type of central nervous system  
2 lesion. Respondent concluded that "hopefully future diagnostic tests will be more  
3 revealing."<sup>70</sup>

4 83. Respondent's June 18, 2008 progress note indicated that SJ had been diagnosed  
5 with lupus.<sup>71</sup>

6 84. After that progress note, Respondent made little mention of SJ's lupus or other co-  
7 morbid conditions. Nothing in progress notes indicates any communication between  
8 Respondent and SJ's other physicians.

9 *Respondent's failure to more carefully consider what additional treatment modalities*  
10 *might have been available to SJ other than high-dose opioids*

11 85. Respondent's July 31, 2008 progress note indicated that he administered a trigger  
12 point injection to SJ.<sup>72</sup>

13 86. Respondent's October 16, 2008 progress note indicated that he administered  
14 another trigger point injection to SJ.<sup>73</sup>

15 87. Respondent's January 8, 2009 progress note indicated that SJ requested a  
16 medication to help her decrease smoking and was given a TENS unit for her back.<sup>74</sup>

17 88. Other than these two injections and the TENS unit, it does not appear that  
18 Respondent ordered any other treatment modalities.

19 *Respondent's medical records were inadequate in that the notes were illegible and there*  
20 *were gaps in the chronology of the prescriptions*

21 89. Respondent's handwritten notes are extremely difficult for a layperson to read.

22 90. The majority of progress notes throughout Respondent's treatment of SJ are very  
23 brief and do not outline any rationale for the escalating dosage of opioids or overall  
24 treatment plan.

25 91. Notably, the two progress notes in evidence that were created after Respondent  
was notified of the complaint were more detailed.<sup>75</sup>

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<sup>69</sup> *Id.* at 75.

<sup>70</sup> *Id.* at 71.

<sup>71</sup> *Id.* at 66.

<sup>72</sup> *Id.* at 65.

<sup>73</sup> *Id.* at 64.

<sup>74</sup> *Id.* at 62.

Other Evidence

92. Respondent, Dr. Ruskin, and Dr. Grove all agreed that there is no ceiling for opioid medications and that there is no maximum dosage. However, Dr. Ruskin testified that high doses of opioid medications can kill people.<sup>76</sup>

93. When asked if it was fair to say that patients coming to him were seeking narcotics medications, Respondent stated, "I would say they are coming to me for pain relief, and I use narcotics for that. Because that is the modality that works."<sup>77</sup>

94. Respondent testified that he "followed every guideline, every rule, every law, if you will."<sup>78</sup> Respondent concluded that he could "find nothing that [he had] done wrong, after frequent self-examination to get to this point."<sup>79</sup>

95. Both Dr. Ruskin and Dr. Grove testified that SM was harmed by Respondent's conduct in that she was placed in a situation of extreme opioid dependence. Dr. Ruskin stated in his report that patient SJ was unnecessarily rendered extremely opioid dependent, as well. Additionally, there was the potential for overdose and death.

96. Respondent presented the testimony of PP, a patient that had been treated by Dr. Grove prior to seeking treatment from Respondent.

97. PP was treated by Dr. Grove from September 2008 through March 2012. During that time, PP repeatedly complained of pain and requested additional medications. Dr. Grove increased the medications, but at a certain point refused any additional increases.

98. Eventually PP sought treatment from Respondent who increased his medications as he had requested. PP testified that Respondent had started prescribing oxycontin and had almost tripled his dosage of oxycodone.

99. Although PP lives in Maricopa County, he has a friend drive him to Tucson once a month to see Respondent, a trip of one and a half to two hours each way. PP also has to have someone drive him to and from work because of the level of medications he is taking.<sup>80</sup>

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<sup>76</sup> *Id.* at 23b-25.

<sup>76</sup> Tr. 219:2-7.

<sup>77</sup> Tr. 743:7-12.

<sup>78</sup> Tr. 884:16-17.

<sup>79</sup> Tr. 884:17-19.

<sup>80</sup> Tr. 481:17-482:9.

1 100. PP testified that Respondent had suggested surgery at some point during his  
2 treatment, but because of a previous surgery that did not go well, PP was unwilling to  
3 undergo another surgery.<sup>81</sup>

4 101. PP stated that Respondent's long-term plan of care was to prescribe medication to  
5 maintain his ability to work until he was able to retire, at least 14 years from now.<sup>82</sup>

6 102. Respondent pointed out a typographical error in Dr. Grove's medical records for  
7 PP that resulted in a different diagnosis being listed in the records. Dr. Grove  
acknowledged the error and took full responsibility for the mistake.

#### 8 Prior Disciplinary and Non-Disciplinary History

9 103. On February 4, 2009, Respondent consented to a Letter of Reprimand for issues  
involving inappropriate prescribing and inadequate medical records.<sup>83</sup>

10 104. On April 27, 2010, the Board issued Respondent an Order for Continuing Medical  
11 Education for "prescribing extremely high doses of oxycodone to a high risk patient with a  
12 previous history of self medication and psychiatric issues in violation of A.R.S. § 32-  
1401(27)(q)."<sup>84</sup>

13 105. Respondent appealed the Order for Continuing Medical Education and an  
14 administrative hearing was held, after which the order was upheld.<sup>85</sup>

15 106. In fulfilling the Order for Continuing Medical Education, Respondent attended the  
16 PACE prescribing course. However, Respondent testified that he did not learn anything  
17 new from the course.<sup>86</sup>

#### 18 CONCLUSIONS OF LAW

19 1. The Board has jurisdiction over Respondent and the subject matter in this case.

20 2. Pursuant to A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B), the Board has  
21 the burden of proof in this matter. The standard of proof is by clear and convincing  
evidence. A.R.S. § 32-1451.04.

22  
23 <sup>81</sup> Tr. 489:11-14.

24 <sup>82</sup> Tr. 489:14-490:8.

<sup>83</sup> State's Exhibit 19.

25 <sup>84</sup> State's Exhibit 20.

<sup>85</sup> *Id.*

<sup>86</sup> Tr. at 739:3-10.

1 3. The legislature created the Board to protect the public. See Laws 1992, Ch. 316, §  
2 10.

3 4. A.R.S. 32-1401(2) provides that

4 "Adequate records" means legible medical records, produced by hand or  
5 electronically, containing, at a minimum, sufficient information to identify the  
6 patient, support the diagnosis, justify the treatment, accurately document  
the results, indicate advice and cautionary warnings provided to the patient  
and provide sufficient information for another practitioner to assume  
continuity of the patient's care at any point in the course of treatment.

7 5. A.R.S. § 32-1401(27)(q) defines unprofessional conduct as "[a]ny conduct or  
8 practice that is or might be harmful or dangerous to the health of the patient or the  
9 public."

#### 10 Patient SM

11 6. As to SM, Respondent argued that he did not deviate from any applicable  
standard of care during the course of his treatment of SM.

12 7. Respondent's progress notes were extremely brief and most often did not include  
13 any physical examination findings or a clear plan of care for SM.

14 8. The Board established by clear and convincing evidence that Respondent  
15 deviated from the standard of care by failing to provide a coherent and organized history,  
physical examination, assessment, and plan of care for SM.

16 9. While Respondent asserted that physical therapy and steroid injections were not  
17 appropriate for SM's pathology, nothing in Respondent's records indicated any other  
18 treatment modalities were considered at any point of SM's course of treatment other than  
19 to increase her opioid dosage until she quit smoking, lost weight, and had surgery.

20 10. Respondent asserted that physical therapy is not a treatment that provides long-  
21 term relief of pain and only reduces pain complaints while the patient is undergoing the  
22 therapy. Respondent also asserted that epidural steroid injections do not provide long-  
23 term relief beyond three months following the treatment. The Administrative Law Judge  
notes that opioid medications similarly do not provide long-term relief of pain and only  
24 reduce pain complaints while the patient is taking the medications.

25 11. The Board established by clear and convincing evidence that Respondent  
deviated from the standard of care by failing to more thoroughly consider what other

1 treatment modalities might be available rather than continuing to escalate SM's opioid  
2 dosage.

3 12. While Respondent asserted that the opioid dosage for SM was appropriate to  
4 control her pain level, Respondent's records do not document why such increases were  
5 necessary. On SM's second visit to Respondent, Respondent doubled SM's oxycodone  
6 dosage from 150 tablets of oxycodone 30mg per 30 days to 300 tablets of oxycodone  
7 30mg per 30 days, despite finding that SM was "stabilized on her medications"

8 13. The Board established by clear and convincing evidence that Respondent  
9 deviated from the standard of care by failing to document a clear rationale as to why he  
10 felt it was necessary to accelerate SM's opioid dosage to the level of 600 morphine mg-  
11 equivalents per day.

12 14. Respondent testified that he properly treated SM in light of her co-morbid  
13 conditions. Respondent did not feel he needed to communicate with SM's behavioral  
14 health providers because he was addressing her pain issues. Respondent also asserted  
15 that he was aware of SM's addiction history and took that into account during his  
16 treatment of SM. Respondent also dismissed the findings of the hospitalist that SM was  
17 on an excessive amount of opioids that could have led to some of her symptoms.

18 15. Respondent's dismissal of SM's mental health issues was concerning in that  
19 Respondent did not appreciate the need for open communication when dealing with a  
20 complex patient. Additionally, Respondent did not seem to have any concern with the  
21 high doses of opioids he was prescribing a patient who had a 10-year history of  
22 methamphetamine addiction that reportedly ended less than two years prior to starting  
23 treatment with Respondent.

24 16. The Board established by clear and convincing evidence that Respondent  
25 deviated from the standard of care by failing to take into account her co-morbid  
conditions, including her 10-year history of methamphetamine addiction, as well as  
bipolar disorder, and failing to contact SM's behavioral health specialists in order to  
discuss these conditions in light of the high opioid doses she was requiring.

1 17. Respondent expressed he did not have any concerns with SM using multiple  
2 pharmacies based on the shortage of oxycodone in the Tucson area. Respondent also  
3 dismissed the significance of SM receiving prescriptions for opioids from other providers.

4 18. While Respondent may not have had an issue with SM's failure to comply with the  
5 narcotics agreement, he failed to document any conversations with SM indicating that he  
6 was even aware of her failures to comply.

7 19. Respondent also asserted that he appropriately dealt with SM's use of diverted  
8 Methadone and the theft of her medications by her son.

9 20. SM's inconsistency as to when the medications were taken by her son calls into  
10 question the veracity of her story. Had Respondent more clearly recorded in his progress  
11 notes the report he received from SM regarding the incident, there would be a  
12 contemporaneous version of events that could have shed more light on the events.

13 21. The Board established by clear and convincing evidence that Respondent  
14 deviated from the standard of care by failing to recognize and intervene when there were  
15 clear signs of opioid misuse and diversion, including violations of SM's opioid agreement  
16 by the use of multiple pharmacies, SM's report of taking diverted methadone, and SM's  
17 report that her medication had been stolen by her son.

18 22. With respect to Respondent's medical records of SM, Respondent acknowledged  
19 that the records would be difficult for a physician who did not practice pain management  
20 to follow.

21 23. Respondent's medical records were seriously lacking in that there was little to  
22 support the diagnosis, justify the treatment, accurately document the results, indicate  
23 advice and cautionary warnings provided to the patient, and to provide sufficient  
24 information for another practitioner to assume continuity of the patient's care at any point  
25 in the course of treatment.

26 24. The Board established by clear and convincing evidence that Respondent violated  
27 A.R.S. § 32-1401(2) by failing to maintain adequate records as defined by the statute.

Patient SJ

28 25. As to SJ, Respondent argued that he did not deviate from any applicable standard  
29 of care during the course of his treatment of SJ.

- 1 26. Respondent's progress notes were quite brief, most often without any physical  
2 examination findings and without a clear plan of care for SJ.
- 3 27. The Board established by clear and convincing evidence that Respondent  
4 deviated from the standard of care by failing to provide a coherent and organized history,  
5 physical examination, assessment, and plan of care for SJ.
- 6 28. While Respondent asserted that the opioid dosage for SJ was appropriate to  
7 control her pain level, Respondent's records do not document why such increases were  
8 necessary. Significantly, Respondent decided to cut SJ's dosage in half without warning.
- 9 29. The Board established by clear and convincing evidence that Respondent  
10 deviated from the standard of care by failing to provide clear justification as to why it was  
11 necessary to maintain SJ on the equivalent of almost 900 mg of morphine a day.
- 12 30. Respondent argued that he appropriately treated SJ with respect to her co-morbid  
13 conditions.
- 14 31. While Respondent's initial progress notes indicated SJ's case was complex and  
15 made references to SJ seeing a rheumatologist, once SJ was diagnosed with lupus,  
16 there were very few mentions of SJ's other conditions and/or providers.
- 17 32. The Board established by clear and convincing evidence that Respondent  
18 deviated from the standard of care by failing to clarify SJ's co-morbid conditions and work  
19 more closely with her rheumatologist and primary care physicians.
- 20 33. Respondent asserted other treatment modalities were not appropriate for SJ's  
21 pathology. Respondent provided two trigger point injections and a TENS unit for SJ early  
22 in her treatment, but it does not appear from Respondent's records that any other  
23 treatment modalities were considered, other than to continue increasing her opioid  
24 dosage.
- 25 34. The Board established by clear and convincing evidence that Respondent  
deviated from the standard of care by failing to more carefully consider what additional  
treatment modalities might have been available to SJ other than high-dose opioids.
35. With respect to Respondent's medical records of SJ, Respondent acknowledged  
that it would be difficult for a physician not practicing pain management to follow.

1 36. Respondent's medical records were seriously lacking in that there was little  
2 included to support the diagnosis, justify the treatment, accurately document the results,  
3 indicate advice and cautionary warnings provided to the patient, and to provide sufficient  
4 information for another practitioner to assume continuity of the patient's care at any point  
in the course of treatment.

5 37. The Board established by clear and convincing evidence that Respondent violated  
6 A.R.S. § 32-1401(2) by failing to maintain adequate records as defined by the statute.

7 Summary

8 38. The deviations in the standard of care identified above constitute unprofessional  
9 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might  
be harmful or dangerous to the health of the patient or the public.")

10 39. The legislature created the Board to protect the public. See Laws 1992, Ch. 316, §  
11 10. When determining the appropriate disciplinary action to be imposed, "the board shall  
12 consider all previous nondisciplinary and disciplinary actions against a licensee." A.R.S. §  
32-1451(U).

13 40. Considering Respondent's disciplinary history with the Board in addition to  
14 Respondent's repeated acts of unprofessional conduct, the evidence established that he  
15 engages in conduct or practices that are or might be harmful or dangerous to the health of  
16 his patients or the public. Therefore, the Board should revoke Respondent's license to  
practice allopathic medicine.

17 ORDER

18 MD-12-0771A

19 Based on the foregoing, it is ORDERED that on the effective date of the Board's  
20 final order in this matter, the Board revoke License No. 9796 for the practice of allopathic  
21 medicine in Arizona previously issued to Respondent Robert C. Osborne, M.D.

22 RIGHT TO PETITION FOR REHEARING OR REVIEW

23 Respondent is hereby notified that he has the right to petition for a rehearing or  
24 review. The petition for rehearing or review must be filed with the Board's Executive  
25 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The

petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 16<sup>th</sup> day of June, 2014.

THE ARIZONA MEDICAL BOARD

By C. Lloyd Vest, II  
C. LLOYD VEST, II  
Executive Director

ORIGINAL of the foregoing filed this  
16<sup>th</sup> day of June, 2014 with:

Arizona Medical Board  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

COPY of the foregoing filed this  
16<sup>th</sup> day of June, 2014 with:

Cliff J. Vanell, Director  
Office of Administrative Hearings  
1400 W. Washington, Ste 101  
Phoenix, AZ 85007

Executed copy of the foregoing  
mailed by U.S. Mail this  
16<sup>th</sup> day of June, 2014 to:

James W. Stuehringer, Esq.  
Waterfall, Economidis, Caldwell, Hanshaw, Villamana, P.C.  
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1 **BEFORE THE ARIZONA MEDICAL BOARD**

2  
3 In the Matter of

4 **ROBERT C. OSBORNE, M.D.**

5 Holder of License No. 9796  
6 For the Practice of Allopathic Medicine  
7 In the State of Arizona.

**CASE NO. 13A-9796-MDX**  
**Board Case No. MD-12-0771A**

**ORDER DENYING MOTION FOR  
REHEARING OR REVIEW**

8 At its public meeting on August 6, 2014, the Arizona Medical Board ("Board") considered a  
9 Motion for Rehearing or Review filed by Robert C. Osborne, M.D. ("Respondent"). Respondent  
10 requested the Board rehear or review its June 16, 2014 Findings of Fact, Conclusions of Law and  
11 Order for Revocation of Respondent's license in Case no. MD-12-0771A. The Board voted to deny  
12 the Respondent's Motion for Rehearing or Review upon due consideration of the facts and law  
13 applicable to this matter.

14 **ORDER**

15 IT IS HEREBY ORDERED that:

16 Respondent's Motion for Rehearing or Review is denied. The Board's June 16, 2014  
17 Findings of Fact, Conclusions of Law and Order of Revocation in Case no. MD-12-0771A is  
18 effective and constitutes the Board's final administrative order in this matter.

19 **RIGHT TO APPEAL TO SUPERIOR COURT**

20 Respondent is hereby notified that he has exhausted his administrative remedies.  
21 Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from  
22 this decision pursuant to title 12, chapter 7, article 6 of Arizona Revised Statutes.  
23  
24  
25

1 DATED this 6<sup>th</sup> day of August, 2014.

2 ARIZONA MEDICAL BOARD

3  
4 By C. Lloyd Vest, II  
5 C. LLOYD VEST, II  
6 Executive Director

7 ORIGINAL of the foregoing filed this  
8 6<sup>th</sup> day of August, 2014 with:

9 The Arizona Medical Board  
10 9545 East Doubletree Ranch Road  
11 Scottsdale, Arizona 85258

12 Executed copy of the foregoing  
13 mailed by U.S. Mail this 6<sup>th</sup> day  
14 of August, 2014 to:

15 James W. Stuehringer, Esq.  
16 Waterfall, Economidis, Caldwell, Hanshaw, Villamana, P.C.  
17 Williams Center, 8<sup>th</sup> Floor  
18 5210 E. Williams Circle  
19 Tucson, Arizona 85711-4482  
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21 Mary Robey  
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24  
25